Claims Clues

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AHCCCS Awards 5 ALTCS Contracts

Five long term care program contractors have been awarded contracts to serve the ALTCS elderly and physically disabled (EPD) populations outside of Maricopa County. The contracts are effective October 1.

Each of the 14 counties will be served by one program contractor. Contracts were awarded to:

- Pima Health System for Pima and Santa Cruz counties. Lifemark Health Plans is the current program contractor for Santa Cruz County.
- Yavapai County Long Term Care for Yavapai County
- Cochise Health Systems for Cochise, Graham, and Greenlee counties. Lifemark is the current program contractor for Greenlee County.
- Lifemark for Apache, Coconino, La Paz, Mohave, Navajo, and Yuma counties.
- Pinal County Long Term Care for Pinal and Gila counties. Lifemark is the current program contractor for Gila County.

Last year, AHCCCS awarded contracts to three program contractors to serve the EPD population in Maricopa County, marking the first time ALTCS members had a choice of program contractors. The three program contractors are Maricopa Long Term Care Plan, Mercy Care Plan, and Lifemark. ❒

OLA Outlines Provider Grievance Procedure

Providers should exhaust all authorized claims processing procedures before filing a grievance with the AHCCCS Office of Legal Assistance (OLA).

Providers should not file a grievance when a claim has been denied for easily correctable errors (e.g., inappropriate use of modifiers, failing to indicate emergent services, etc.). Such errors should be corrected by resubmitting the claim to the AHCCCS Claims Department.

Providers should consult Chapter 5 of the *AHCCCS Fee-For-Service Provider Manual* for information on resubmitting claims. The manual is available on the AHCCCS Web site at www.ahcccs.state.az.us.

Providers also may correct many claim errors over the telephone by contacting the Claims Customer Service Unit. To correct errors over the telephone or to obtain help with resubmitting claims, call the Customer Service Unit at:

- (602) 417-7670 (Phoenix area)
- 1-800-794-6862 (In state)
- 1-800-523-0231 (Out of state)

If the provider has exhausted all authorized processing procedures and still has a disputed claim, the provider has the right to file a grievance with OLA.

A provider must file a grievance no later than 12 months from the ending date of service, 12 months from the date of eligibility posting, or 60 days from the date of the adverse action, whichever is latest. The 60-day provision does not apply to claims that do not meet the 12-month clean claim deadline.

The date the grievance is received by OLA is considered the date the grievance is filed. The date of the adverse action is the status date for the claim as printed on the Remittance Advice.

The grievance must state in detail the basis of the grievance and the relief requested (e.g., payment).

Grievances lacking specificity may be denied. The provider must include any documents that support the facts of the case. Providers also must include the name and telephone number of a contact person.

A grievance must be submitted in writing. It should be mailed to:

AHCCCS Office of Legal Assistance
Mail Drop 6200
P.O. Box 25520
Phoenix, AZ 85002

The grievance also may be hand delivered to:

AHCCCS Office of Legal Assistance
701 E. Jefferson Street, Suite 200
Phoenix, AZ 85034

Providers also may fax a grievance to (602) 253-9115. ❒

Guidelines Offered for Submitting Documentation

The AHCCCS Claims Medical Review Unit is offering guidelines to providers for submitting documentation with fee-for-service claims.

While it is impossible to offer specific guidelines for each situation, the tables below are designed to give providers some general guidance regarding submission of documentation. Also, not all fee-for-service claims submitted to AHCCCS are subject to Medical Review. ❒

HCFA 1500 Claims		
Billing For	**Documents Required**	**Comments**
Surgical procedures	History and physical, operative report	
Missed abortion /Incomplete abortion Procedures (all CPT codes)	History and physical, ultrasound report, operative report, pathology report	Information must substantiate fetal demise.
Emergency room visits	Emergency room record	Billing physician's signature must be on ER record
Anesthesia	Anesthesia records	Include begin and end time
Pathology	Pathology reports	
E&M services	Progress notes, History and physical, office records, discharge summary, consult reports	Documentation should be specific to code billed
Radiology	X-ray/Scan reports	
Medical procedures	Procedure report, history and physical	Examples: Cardiac catheterizations, Doppler studies, etc.

UB-92 Claims		
Billing for	**Documents Required**	**Comments**
Observation	All documents required by statute and observation records	If labor and delivery, send labor and delivery records
Missed abortion/Incomplete abortion	All documents required by statute, ultrasound report, operative report, pathology report	Information must substantiate fetal demise
NICU/ICU tier claims	All documents required by statute	MD orders and MD progress notes to substantiate level of care billed
Outlier	All documents required by statute	

Providers should *not* submit the following unless specifically requested to do so:

- Emergency admission authorization forms
- Patient follow-up care instructions
- Nurses notes
- Blank medical documentation forms
- Consents for treatment forms
- Operative consent forms (exception: BTL & hysterectomy)
- Ultrasound/X-ray *films*
- Medifax information
- Nursing care plans
- Medication administration records (MAR)
- DRG/Coding forms
- Medical documentation on prior authorized procedures/hospital stays
- Entire medical records ❒

Need Help with a Claim?

Contact Claims Customer Service
(602) 417-7670 (Phoenix area)
(800) 794-6862 (In state)
(800) 523-0231 (Out of state)

Hours: 7:00 a.m. – Noon
12:30 – 4:00 p.m.